

V. S. No. 2
 OOM-2-43
 Rev. 5-17-39
 X33697

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **35005**

FILED DEC 31 1945
 Registration District No. **318**

Primary Registration District No. **1003** Registrar's No. **10329**

1. PLACE OF DEATH:
 (a) County.....
 (b) City or town. St. Louis
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Homer Phillips Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution. 4 days
(Specify whether
 In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State. Missouri (b) County.....
 (c) City or town. St. Louis
(If outside city or town limits, write "RURAL")
 (d) Street No. 717 N Leonard
(If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME Acie Williams
 3. (b) If veteran, name war..... 3. (c) Social Security No.....

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Nov. day 20
 year 1945 hour 3 minute 45 P M.

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced. Married
 6. (b) Name of husband or wife Bertha 6. (c) Age of husband or wife if alive. Unk years

21. I hereby certify that I attended the deceased from 11-17, 1945, to 11-20, 1945, that I last saw him alive on 11-20, 1945, and that death occurred on the date and hour stated above.

7. Birth date of deceased January 10 1899
(Month) (Day) (Year)
 8. AGE: Years 56 Months 10 Day 10 If less than one day
hr. min.

Immediate cause of death.....
Massive Subarachnoid Hemorrhage
 Due to.....
 Due to.....

9. Birthplace Ark.
(City, town, or county) (State or foreign country)
 10. Usual occupation Nil

Other conditions.....
(Include pregnancy within 3 months of death)
 Major findings:
 Of operations.....
 Of autopsy Yes

11. Industry or business.....
 12. Name Unknown
 13. Birthplace "
(City, town, or county) (State or foreign country)
 14. Maiden name Laura Alexander
 15. Birthplace Ark.
(City, town, or county) (State or foreign country)

PHYSICIAN
 Underline the cause to which death should be charged statistically.

16. (a) Informant Bertha Williams, wife
 (b) Address 717 N Leonard

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify).....
 (b) Date of occurrence.....
 (c) Where did injury occur?.....
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?.....

17. (a) Burial (b) Date thereof NOV 29 1945
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation CITY CEMETERY
 18. (a) Signature of funeral director J. B. Huggins
 (b) Address City Health Dept
 19. (a) NOV 29 1945 (b) J. F. Brudick
(Date received local registrar's) (Registrar's signature)

While at work?..... (Specify type of place)
 (c) Means of injury.....
 23. Signature B. H. Phillips (M. D. or other)
 Address 7601 N Whittier Date signed 11/26

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.